

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, ET AL.,)	
)	CV No. 18-2340
Plaintiffs,)	
)	Washington, D.C.
vs.)	June 4, 2019
)	10:45 a.m.
CVS HEALTH CORPORATION, ET AL.,)	
)	Day 1
Defendants.)	
)	Morning Session

TRANSCRIPT OF MOTIONS HEARING
BEFORE THE HONORABLE RICHARD J. LEON
UNITED STATES SENIOR DISTRICT JUDGE

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WITNESSES

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1 P R O C E E D I N G S

2 DEPUTY CLERK: All rise. The United States
3 District Court for the District of Columbia is now in
4 session, the Honorable Richard J. Leon presiding. God save
5 the United States and this Honorable Court. Please be
6 seated and come to order.

7 The matter before the court is Civil Action
8 No. 18-2340, the United States of America, et al., versus
9 CVS Health Corporation, et al.

10 Counsel, please come forward and state your names
11 for the record.

12 MR. OWEN: Good morning, Your Honor. Jay Owen
13 representing the United States.

14 THE COURT: Welcome.

15 MR. FITZGERALD: Good morning, Your Honor.
16 Scott Fitzgerald, also on behalf of the United States.

17 THE COURT: Welcome.

18 MR. MUCCHETTI: Good morning, Your Honor.
19 Peter Mucchetti on behalf of the United States.

20 THE COURT: Welcome.

21 MR. ALVARADO: Good day, Your Honor. Jesus M.
22 Alvarado-Rivera on behalf of the United States.

23 THE COURT: Are you all antitrust division?

24 MR. OWEN: Yes, Your Honor.

25 THE COURT: How many have you got here?

1 MR. OWEN: There will be four of us at the table.

2 THE COURT: Well, the rest can sit down. We don't
3 need all of these people entering an appearance.

4 MR. OWEN: These are not all United States.

5 THE COURT: No. I appreciate that.

6 Are you antitrust, too?

7 MS. BRADY: I'm not with the United States. I'm
8 with the state of Florida.

9 THE COURT: State of Florida? All right. Well,
10 enter an appearance.

11 MS. BRADY: Lizabeth Brady with the State of
12 Florida, Attorney General's Office.

13 THE COURT: Great.

14 MS. LEE: Malinda Lee on behalf of Plaintiff State
15 of California, on behalf of all plaintiff states, which
16 include California, Florida, Mississippi, Washington, and
17 Hawaii.

18 THE COURT: Welcome.

19 MR. PITTS: Good morning, Your Honor.

20 Jonathan Pitt from Williams & Connolly, representing
21 CVS Health.

22 THE COURT: Welcome.

23 MR. COWIE: Good morning, Your Honor.

24 Michael Cowie from Dechert on behalf of CVS Health.

25 THE COURT: Welcome.

1 MR. HABASH: Good morning, Your Honor.

2 Rani Habash from Dechert on behalf of CVS Health.

3 THE COURT: Welcome.

4 MR. McGINLEY: Good morning, Your Honor.

5 Michael McGinley from Dechert on behalf of CVS Health.

6 THE COURT: Welcome.

7 MR. QUILLEN: Good morning, Your Honor.

8 Henry Quillen from Whatley Kallas on behalf of the American
9 Medical Association.

10 THE COURT: Welcome.

11 MR. ALLEN: Good morning, Your Honor. Henry Allen
12 for The American Medical Association.

13 THE COURT: Welcome.

14 MR. BALTO: Good morning, Your Honor. David Balto
15 on behalf of Consumer Action and the United States Public
16 Interest Research Group.

17 THE COURT: Welcome.

18 MR. BARLOW: Good morning, Your Honor.

19 Andre Barlow on behalf of Consumer Action and U.S. PIRG.

20 THE COURT: Welcome.

21 MR. ARONICA: Good morning, Judge. Joe Aronica
22 From Duane Morris on behalf of the AIDS Healthcare
23 Foundation.

24 THE COURT: Welcome.

25 MR. CASEY: Good morning, Your Honor. Chris Casey

1 from Duane Morris on behalf of the AIDS Healthcare
2 Foundation.

3 THE COURT: Welcome.

4 MR. McCONNELL: Good morning, Your Honor.
5 Sean McConnell from Duane Morris on behalf of the AIDS
6 Healthcare Foundation.

7 THE COURT: Welcome.

8 (Pause)

9 THE COURT: All right, Counsel. We're here to
10 hear the testimony of the first witness, Dr. Sood.

11 Who will be presenting him?

12 MR. OWEN: Your Honor, if I may, one preliminary
13 matter for the United States.

14 THE COURT: You can approach.

15 Counsel, one counsel for the amici.

16 (Bench conference)

17 THE COURT: What's your issue?

18 MR. OWEN: Your Honor, we appreciate that the
19 Court has already ruled on several evidentiary motions prior
20 to this matter. But in order to reflect the record and note
21 the specific questions --

22 THE COURT: "In order to reflect the record"?
23 What's that mean?

24 MR. OWEN: I'm sorry, Your Honor.

25 In order to keep the record clear --

1 THE COURT: The record is clear right now.

2 What's your issue?

3 MR. OWEN: The United States would like to object
4 to particular questions in certain categories --

5 THE COURT: There will be no objections. You're
6 not here for that purpose.

7 Have you got anything else?

8 MR. OWEN: No, Your Honor.

9 THE COURT: Thank you.

10 (Open court)

11 THE COURT: Dr. Sood, come on up.

12 He can be sworn.

13 DEPUTY CLERK: Raise your right hand.

14 (Witness is placed under oath.)

15 DEPUTY CLERK: Please be seated.

16 THE COURT: All right.

17 Dr. Sood, before you start, you need to understand
18 something: This is not a USC classroom. I went to college
19 many, many years ago, maybe 50. There was no such a thing
20 as slide decks back then.

21 When I had the AT&T trial last year, I learned
22 about slide decks and how they've permeated not only
23 America's universities but corporate boardrooms as well.

24 Your testimony today will not be by slide deck.
25 We're not going to use any of the slide decks. He's going

1 to ask you questions --

2 This is old school. He's going to ask you
3 questions. You're going to give answers to the best of your
4 ability.

5 And I might have some questions for you. In fact,
6 I'm sure I will have some questions for you. That's the
7 first point.

8 The second point is, if you have something of this
9 type, which was in your previous filing, that can be used to
10 help explain whatever it is you've got to explain.

11 But slide decks, no, we don't testify by slide
12 decks, okay?

13 THE WITNESS: Yes, sir.

14 THE COURT: All right.

15 When you're ready to proceed, you may proceed.

16 MR. QUILLEN: Thank you.

17 THE COURT: And, by the way, you and both sides
18 can use leading questions. It will help focus his
19 attention. This is not an adversarial proceeding.

20 I want to remind those in the audience, using
21 electronic equipment will be the grounds for being held in
22 contempt of court, and I'll deal with you directly.

23 I don't want to have any instance of electronic
24 equipment on, and that includes counsel's table. No cell
25 phones on, no laptops on.

1 This proceeding is on the record; there is a
2 record of it and there will be a record of it for all to
3 see.

4 Whenever you're ready.

5 MR. QUILLEN: Thank you, Your Honor.

6 And the presentation you were referring to does
7 have a handful of slides of the nature you just described
8 that would be useful for the witness to refer to, so may I
9 bring the --

10 THE COURT: You can give him that.

11 MR. QUILLEN: -- presentation?

12 THE COURT: Does the witness have any water if he
13 needs water? Did you bring him water?

14 Do you have some water?

15 Someone will bring it to you. Sit down, Doctor.

16 Relax.

17 THE WITNESS: Thank you.

18 THE COURT: And just to look ahead a little bit
19 here, we're going to go to 12:15 for the first segment. He
20 has two hours budgeted, so we probably won't finish him this
21 morning. We'll take a luncheon break, and we'll come back
22 afterwards and we'll hear the rest of his testimony, then
23 the other two witnesses' testimony today.

24 We will not get to the witnesses for CVS and the
25 Department of Justice that they have -- and Aetna. We will

1 not get to them today, all right? Just so you have a little
2 overview of where we're going.

3 MR. QUILLEN: Thank you, Your Honor.

4 THE COURT: Go right ahead.

5 - - -

6 DIRECT EXAMINATION

7 - - -

8 NEERAJ SOOD, WITNESS FOR THE AMICUS AMERICAN MEDICAL
9 ASSOCIATION, HAVING BEEN DULY SWORN, TESTIFIED AS FOLLOWS:

10 DIRECT EXAMINATION

11 BY MR. QUILLEN:

12 Q Dr. Sood, could you give your full name for the
13 record, please, and your academic position?

14 A My name is Neeraj Sood, and I'm a professor of
15 health policy and economics at the Sol Price School of
16 Public Policy at U.S.C.

17 Q And what are some of your academic research
18 interests that are most relevant to what we're discussing
19 today?

20 A Sure.

21 So I have published more than 100 papers in health
22 policy and economics, and several of those papers are on the
23 Medicare market, as well as on the prescription drug market.

24 My recent paper on the pharmaceutical supply chain
25 was cited by the Council of Economic Advisers.

1 I am on the editorial board or associate editor
2 and co-editor of several journals in my field, such as the
3 Journal of Health Economics, Journal of Policy Analysis and
4 Management and Health Services Research.

5 I'm also a research associate at NBER, which is a
6 premier economic research organization.

7 Q Broadly speaking, what subjects do you intend to
8 testify about today?

9 A So I want to answer one key question in today's
10 testimony, which is that: Did the divestiture of Aetna's
11 PDP, or prescription drug plan, assets to WellCare, will
12 that divestiture restore competition to the pre-merger
13 levels?

14 And once I've answered that question, I also want
15 to comment on some of the claimed efficiencies of this
16 transaction which were in the proposed testimony of other
17 witnesses.

18 Q Can you describe what a PDP is.

19 A Sure.

20 So a PDP, or a prescription drug plan, is a
21 standalone plan that only covers prescription drugs, and it
22 is offered to people who are eligible for Medicare.

23 So this is part of the Medicare Part D program.

24 And so unlike typical insurance where -- which
25 would cover your hospital bills, your doctor bills, and your

1 drugs, a PDP only covers drugs and only people in Medicare
2 are eligible for it.

3 Q In your opinion, what are some of the key features
4 of the PDP market as it relates to the issues in this case?

5 A So I think there are four key features of the PDP
6 market that are relevant for this case.

7 So the first thing, as I said, is, if you are
8 eligible for Medicare, then you are in the PDP market. So
9 the consumers here are the elderly. And the elderly
10 typically, since they're retired, have lower incomes, have
11 multiple health conditions.

12 So any potential harm in this market because of
13 this transaction is going to be borne by this one area of
14 the population.

15 The second important feature that we should
16 remember is that since the PDP market is part of Medicare,
17 Medicare or the government actually subsidizes PDP premiums,
18 and also subsidizes certain expenditures if beneficiaries
19 exceed certain expenditures.

20 So if they have more than, say, \$5,000 in
21 expenditures on drugs, then the government kicks in and pays
22 for those drugs rather than the prescription drug plan. So
23 what happens is, as a result of these subsidies, there is a
24 bunch of regulations that plans need to abide by.

25 And this has two consequences for this market on

1 how we think about this transaction. The first is that any
2 increase in market power as a result of this transaction
3 would mean higher cost of subsidizing PDP coverage for the
4 government.

5 And the second, given the subsidies in the
6 regulation, those create barriers to entry into this market.
7 So you just can't -- you know, it's not like opening a shop.
8 You have to plan much in advance. You have to have the
9 capability of understanding all the government regulations
10 and abiding by them if you want to enter this market.

11 THE COURT: Now, hold on a second.

12 You made reference to prescription drug plans.

13 THE WITNESS: Yes.

14 THE COURT: Those are separate from the PDP,
15 right?

16 THE WITNESS: No. So prescription drug plan is
17 the same as PDP.

18 THE COURT: So how about people who are not on --
19 Medicare eligible, do they have prescription drug plans?

20 THE WITNESS: So people who are not Medicare
21 eligible don't have prescription drug plans, so they would
22 either buy insurance on the health insurance exchanges,
23 which would be both covering your hospital and doctor
24 visits, as well as prescription drugs.

25 So PDP is only relevant to plans which are

1 prescription drug only and only Medicare population is
2 eligible for them.

3 THE COURT: Okay.

4 BY MR. QUILLEN:

5 Q How would you describe the role of CVS and Aetna
6 in the prescription drug plan market before the merger?

7 A Sure.

8 So the other feature of the PDP market that is
9 important is that the concentration in the PDP market has
10 been increasing over time. So this transaction is happening
11 in a market where prior mergers have already led to a
12 significant increase in market concentration.

13 And as you asked me that: What is the role of
14 Aetna and CVS in this market?

15 So Aetna and CVS both participate in the PDP
16 market. The PDP market is divided into 34 regions. Each
17 region is either a state or a group of states. And Aetna
18 and CVS, as well as WellCare, participate in all 34 PDP
19 geographic markets or regions.

20 And so what'll happen as a result of this
21 transaction is, we're going to lose Aetna as a competitor
22 from this market; that Aetna will no longer participate in
23 this market.

24 And this is significant for two reasons; first,
25 Aetna has been a very strong competitor in this market, so

1 their market share, from 2009 to 2018, increased from about
2 2 percent to 9 percent. So that's a fourfold increase in
3 market share. So we are not only losing a competitor, we
4 are losing a strong competitor from this market.

5 And the second thing is that the DOJ has
6 acknowledged that Aetna and CVS provide significant
7 head-to-head competition with each other, which means that
8 now, post this merger, that head-to-head competition would
9 be lost, which would be a loss for consumers.

10 BY MR. QUILLEN:

11 Q Can you say more about the population that the PDP
12 market serves?

13 A Sure.

14 So there are about 25 million people enrolled in
15 the PDP market. 21 million of those are over the age of 65.
16 The rest are eligible for Medicaid, not through their age
17 but through disability or some other way.

18 Out of these 21 million people who are above the
19 age of 65, 10 million are actually above 75 years or older.
20 So this is a population with very advanced age.

21 29 percent of the population is eligible for
22 something called the low-income subsidy. So you become
23 eligible for the low-income subsidy if your income is below
24 a certain threshold, which is about 150 percent of the
25 federal poverty line, or you qualify for other low-income

1 benefits such as the Medicaid program or the Supplemental
2 Security Income. So 29 percent of this population actually
3 qualifies for the low-income subsidy.

4 And even the remaining population is not very well
5 to do. These are retired folks. They're not, they don't
6 have -- they're not working right now, so they don't have a
7 source of income.

8 About 68 percent of not the PDP population but
9 Medicare beneficiaries in general suffer from multiple
10 chronic conditions or multiple conditions. So they have
11 hypertension and diabetes or -- you know, at least
12 two conditions.

13 And within this population, the majority have four
14 or more health conditions simultaneously. So this is a
15 population in poor health, who are potentially low income,
16 of advanced age.

17 So any increase in market power that results in an
18 increase in premiums will be borne by this population, and
19 I think that is important to kind of keep in mind as we
20 think about this transaction.

21 THE COURT: How much of that market, 25 million in
22 that market, prior to the mergers being covered by Aetna?

23 THE WITNESS: 9 percent.

24 THE COURT: 9 percent?

25 And what percent was being covered by CVS?

1 THE WITNESS: I think 24 percent.

2 THE COURT: All right. Thank you.

3 BY MR. QUILLEN:

4 Q You mentioned that PDP markets are subsidized.

5 Can you talk more about the subsidy and how the costs break
6 down between the government and the enrollees?

7 A Sure.

8 So what happens in the PDP market is plans are
9 required to submit bids to the government on what they think
10 their total costs or premiums would be.

11 And what the government does is, takes all those
12 bids, calculates an average, and says that the government
13 will pay 75 percent of the average, and beneficiaries are
14 responsible for the remaining part of the premium. So the
15 level of subsidy for an average plan is about 75 percent.

16 In addition, if you are low income or you qualify
17 for the low-income subsidy, then the government subsidizes
18 premiums even more.

19 In fact, in each PDP region, there is a plan that
20 if you qualify for the low-income subsidy, your premiums as
21 a consumer would be zero.

22 And the third way the government subsidizes the
23 PDP plans is that if a beneficiary's expenditures exceed
24 what they call or are in the catastrophic zone, so they
25 exceed a certain threshold, that instead of the plan, now

1 the government starts paying healthcare costs or
2 prescription drug costs for these consumers. So those are
3 three ways that the government subsidizes PDPs.

4 And any increase in market power in the PDP market
5 would mean higher costs of subsidizing those premiums or
6 those PDP market for the government.

7 Q You mentioned that there are 34 geographic markets
8 for PDPs. Are the same plans offered in each market?

9 A Yes.

10 So there are 34 regions, and each region has a
11 uniform choice of plans.

12 So basically if I am in a given region, anyone in
13 a given region will have exactly the same choice of plans
14 within that region.

15 And that choice, that varies across regions. So
16 plans are deciding what, like their bids are going to be and
17 then in which of these 34 markets they want to operate.

18 THE COURT: Let me ask you to stop there.

19 THE WITNESS: Yes, sir.

20 THE COURT: Now, who makes those decisions? Are
21 those the PBMs?

22 THE WITNESS: No.

23 So the decision to operate in which market is made
24 by the health plan and not by the -- as far as I understand,
25 not by the PBM.

1 The PBM's role is to help the health plan with
2 benefit design, with negotiating with pharmacies.

3 THE COURT: For the cost of the individual drugs?

4 THE WITNESS: Yes.

5 And also negotiating with manufacturers for the
6 cost of the drugs.

7 THE COURT: Okay.

8 THE WITNESS: So what they're basically saying is
9 they design the health benefits or they decide how much cost
10 sharing or co-pays or co-insurance there will be for a given
11 drug in a given plan.

12 Then they decide for that given drug how much
13 reimbursement the plan will give to the pharmacy if someone
14 from the plan uses the drug.

15 And they also go to the manufacturer and say, Hey,
16 people in my plan are using this drug, you need to give me a
17 rebate, you need to give me a discount, which they will pass
18 on some of the discount back with the plan, and some of the
19 discount they might keep for themselves.

20 THE COURT: So they're setting prices that apply
21 not only to people under the PDP program, which is the
22 Medicare eligible, but the non-PDP people, right?

23 THE WITNESS: So PBMs operate in the non-PDP
24 market also.

25 THE COURT: That's right.

1 THE WITNESS: Yeah.

2 So they are setting -- in that sense, yeah, they
3 are setting.

4 So what -- technically, the prices are -- for
5 drugs are set by the pharmaceutical company. So there's
6 something called the list price of the drug, which is set by
7 the pharmaceutical company.

8 But then the PBM goes to the pharmaceutical
9 company and negotiates a rebate. And so the net price of
10 the drug is, in some sense, set by the PBM because the
11 net -- what the pharmaceutical firm gets is not the list
12 price but the list price less all rebates and concessions
13 they have offered either to the PBM. And sometimes they
14 offer concessions directly to consumers or to pharmacies.

15 THE COURT: And there's three PBMs that dominate
16 the role of PBM nationwide, correct?

17 THE WITNESS: Yes, sir.

18 THE COURT: They have 70, 75 percent of the
19 market?

20 THE WITNESS: About 70 percent of the market.

21 THE COURT: About 70 percent of the market.

22 And CVS is the largest of the three?

23 THE WITNESS: Yes, sir.

24 THE COURT: So they're setting the prices -- Aetna
25 will now be using CVS's PBM for this purpose, correct?

1 THE WITNESS: So, yes, Aetna already has, so prior
2 to the merger had an agreement with CVS to provide certain
3 PBM services to Aetna. And -- but Aetna also said that they
4 retained some of the PBM functions themselves.

5 So part of the services were being provided by CVS
6 and part were being provided by Aetna.

7 And it is my understanding that post this merger,
8 everything is within the same firm; so in some sense,
9 everything is being provided by CVS.

10 BY MR. QUILLEN:

11 Q And so to sum up, would it be fair to say that the
12 prices that the PBM passes on to a PDP are a major input in
13 the PDP's premiums?

14 A Yes.

15 So the PBM is a major provider of input.

16 So if you're thinking about establishing a
17 prescription drug plan, a lot of key functions are being
18 performed by the PBM.

19 So like to take a car example. It would be like
20 the engine is what the PBM is providing or the servicing of
21 the car is what the PBM is providing, because they are the
22 ones who are negotiating key contracts with manufacturers
23 and pharmacies. They're the ones who are deciding on
24 benefit design. So they -- and they also process claims.
25 So they play a major role.

1 Q And the three PBMs that account for 70 percent of
2 the industry, do they all -- are they all part of companies
3 that offer PDPs?

4 A Yes.

5 So the three big PBMs are CVS; Express Scripts,
6 which owns Cigna; and Optum, which owns -- or Optum, which
7 is owned by United. And all of them are payers in the PDP
8 market.

9 Q So would it be accurate to say that WellCare now,
10 after the merger and divestiture, is a customer of CVS but
11 also a competitor of CVS and the corporations associated
12 with the other PBMs as well?

13 A Yes, that would be accurate.

14 So currently, CVS is the PBM for WellCare. So CVS
15 is providing these key inputs of PBM services to WellCare.

16 At the same time, CVS has its own PDP plans that
17 compete with WellCare.

18 So this would be, again, like to take the car
19 example, if Mercedes and Tesla were competing with each
20 other in the electric car market and the Mercedes electric
21 car actually had Tesla batteries or the Tesla electric
22 system, it's something similar to that.

23 Q Did that actually happen?

24 A That actually did happen in 2014.

25 But those cars were discontinued roughly two years

1 later because, I think -- and now Mercedes is planning to
2 make its own batteries and its own electric system.

3 Q Since we're on the topic of PBMs, let's stay with
4 it.

5 Can you say a little bit more about the functions
6 that a PBM provides for a PDP?

7 A So a PBM provides a variety of functions for the
8 PDP.

9 So the first function would be helping with a
10 benefit design of the PDP.

11 And the second function is helping negotiate
12 rebates with pharmaceutical manufacturers.

13 The third function would be helping negotiate
14 reimbursement to pharmacies.

15 And the fourth function would be processing claims
16 and also providing customer service.

17 So, for example, if on my U.S.C. plan, if I have a
18 problem with a prescription drug claim, I'll probably call a
19 1-800 number of the PBM, who will provide me service.

20 Q As the supplier of PBM services to WellCare,
21 do you think that CVS would have the same incentive to
22 provide the same level of service and pricing to WellCare as
23 it does to Aetna?

24 A It would not, because if you think about just the
25 incentives, if they provide excellent service to WellCare,

1 that makes WellCare a stronger plan. And that means
2 WellCare is going to take market share away from CVS because
3 it's competing with CVS in the same market. And which means
4 CVS will lose because they are providing better service to
5 WellCare.

6 So they have an incentive to provide better
7 service to themselves than to rival plans, because, again,
8 providing better service to your own plan will make your own
9 plan stronger, which would then take market share away from
10 WellCare and other rivals in the PDP market.

11 So the incentives are aligned to kind of provide
12 better care to yourself, rather than to a competing plan
13 like WellCare.

14 THE COURT: And how does CVS's having the Aetna
15 customer base -- it's 21 million people in the customer base
16 of Aetna?

17 THE WITNESS: About 2.2 million people.

18 THE COURT: 2.2 million.

19 How does that assist or strengthen CVS's PBM
20 ability vis-à-vis the other PBM companies?

21 MR. QUILEN: If I may, I think we may be talking
22 about the PDP Aetna enrollees, who were about 2.2 million.

23 The overall Aetna enrollees in all its products
24 are the higher number, the 20-something million.

25 THE COURT: Right.

1 So by virtue of the merger, right --

2 THE WITNESS: Uh-huh.

3 THE COURT: -- CVS's PBM entity, which is in the
4 top three already --

5 THE WITNESS: Yes.

6 THE COURT: -- right, will have the advantage,
7 I will assume -- correct me if I am wrong -- of now being
8 able to represent to the manufacturers, you know:
9 I represent this large group of people who are either in the
10 PDP plan or the non-PDP plan, but they're
11 healthcare-covered.

12 Wouldn't that strengthen their PBM business,
13 vis-à-vis the other PBM company?

14 THE WITNESS: It would.

15 The only caveat I would say is that prior to the
16 merger, Aetna already had an agreement with CVS to provide
17 some PBM services.

18 THE COURT: Okay.

19 THE WITNESS: But you're right that to the extent
20 that that agreement is now being strengthened because you
21 cannot -- so an agreement can be annulled or can be changed
22 or not renewed when a contract is up.

23 So this merger definitely strengthens that
24 position, because now you're not like, well, you're
25 providing some PBM services to 22 million customers. They

1 are our customers.

2 So in that sense, it would strengthen CVS.

3 THE COURT: All right.

4 BY MR. QUILLEN:

5 Q And you said CVS wouldn't have the incentive, the
6 same incentive to provide excellent service to WellCare as
7 it would to Aetna. Does that same logic apply to passing
8 through the rebates that CVS receives from the
9 manufacturers?

10 A Yes.

11 So the same logic would apply that if I pass on
12 more of the rebate dollars that I'm getting from the
13 manufacturer to WellCare, that allows WellCare to lower its
14 cost and lower its premiums and, again, compete with CVS in
15 the PDP market and take away some of their market share.

16 So the same logic would apply for any of the
17 things that PBM, any of the services that PBM is providing
18 to WellCare.

19 BY MR. QUILLEN:

20 Q Would that include CVS's negotiations with
21 pharmacies as well?

22 A Yes.

23 And I think there, it gets even more complicated,
24 because CVS, the PBM --

25 THE COURT: Right.

1 THE WITNESS: -- is negotiating with CVS, the
2 pharmacy, for WellCare or for a rival plan, and you can only
3 manage imagine how those negotiations might happen.

4 So now it's, you know, just to complete this
5 thing, that if you negotiate hard with CVS, the pharmacy,
6 CVS, the pharmacy, loses money; but that benefits WellCare
7 because their costs are lower.

8 And now since and because it benefits WellCare and
9 they can lower their premiums, they can take away
10 market share from CVS, the health plan and the PDP market.

11 So you might lose money now two different ways,
12 one by lowering your margins on the pharmacy business and
13 the other by losing market share in the PDP business.

14 BY MR. OWEN:

15 Q Well, if WellCare feels like it's getting a raw
16 deal from CVS, can't it just go elsewhere?

17 A It could potentially go elsewhere.

18 So I think there are multiple conditions.

19 First, it has to know that it is getting a raw
20 deal or somewhat of a raw deal.

21 And the PBM market is known for being opaque.
22 So it's very difficult to figure out, even as a health plan,
23 what your PBM is actually doing. What discounts had -- did
24 it get from the different entities? How many of those
25 discounts are being passed back to the health plan? Or, you

1 know, what is the level of customer service that they are
2 providing?

3 So there might be subtle ways in which they
4 disadvantage a health plan, and the health plan might not be
5 able to figure out what's happening.

6 So the first thing is the probability of detecting
7 what economists call this phenomena input foreclosure is
8 low.

9 The second thing is, suppose you even detect input
10 foreclosure and you find that CVS is not providing you the
11 service that you expect. What are your options? You will
12 go to some other PBM provider.

13 But the other two PBMs, Express Scripts and Optum,
14 are also owned by health plans that are competing with you.
15 So you will face the same conflict with those other PBMs
16 that you would face with CVS as your PBM.

17 And as -- Your Honor, as you had mentioned
18 earlier, that the PBM market is fairly concentrated. The
19 top three PBMs account for 70 percent of the market. So you
20 don't have a lot of good outside options beyond the top
21 three.

22 And we know that if you go to a smaller PBM, then
23 they don't have that same negotiating power. You cannot go
24 to a PBM that controls 1 million lives and expect big
25 discounts from manufacturers or pharmacies.

1 THE COURT: Let me make sure I understand
2 something here.

3 THE WITNESS: Yes, sir.

4 THE COURT: The PBMs when they're competing with
5 one another, do I understand correctly, they're competing to
6 get the contractual relationship with the health plan
7 providers?

8 THE WITNESS: Yes. Yes, sir.

9 THE COURT: So when they're competing to get a
10 contract to represent the health plan providers, I'm trying
11 to figure out exactly what they're bringing to the table.

12 Would it be accurate to say what they bring to the
13 table is the network of pharmacies?

14 There's 70,000 pharmacies in the United States, as
15 I understand it, roughly.

16 THE WITNESS: Uh-huh.

17 THE COURT: CVS has 7900 of those 70,000.

18 THE WITNESS: Uh-huh.

19 THE COURT: So I would imagine that CVS PBM, when
20 it's trying to get a contract, is emphasizing, look, we've
21 got this network of 7900 pharmacies nationwide. And now
22 with Aetna, they can say, Well, we have 21 million
23 customers, both PDP and non-PDP, who are getting services
24 from us.

25 So that's -- and then we have a such-and-such a

1 track record from negotiating good deals for rebates.

2 THE WITNESS: Yes.

3 THE COURT: Are those the kinds of things that
4 they're putting up as incentives for these health plans to
5 hire them?

6 THE WITNESS: Yes.

7 So when a health plan is thinking of hiring a PBM,
8 what the health plan should care about is, what is the total
9 cost of providing the prescription drug benefit?

10 And as you said, there are two ways to better save
11 money on these total costs. So when you network or when you
12 contract with all these 70,000 pharmacies, you're not only
13 saying that we have a relationship with them, but we've
14 negotiated a low level of reimbursement with them, and
15 that -- we're going to pass on some of those savings back to
16 you as a health plan.

17 And, similarly, what they're saying is that, look,
18 we represent 90 million people. So with 90 million people,
19 when we go negotiate with the pharmaceutical manufacturer,
20 we're going to get a big rebate and we're going to pass on
21 those rebate dollars back to you.

22 So those are the, you could say, like two primary
23 ways in which a PBM can help a health plan lower their
24 costs.

25 THE COURT: Okay.

1 BY MR. OWEN:

2 Q In a market like the PBM market where three firms
3 control 70 percent of the business, I mean, would you
4 expect, as an economist, that if WellCare leaves CVS, it's
5 going to get the same sort of pricing from Optum or
6 Express Scripts that it would in a highly competitive
7 market?

8 A No.

9 So, again, and as I said, the prices are
10 correlated with market concentration. So the higher the
11 market concentration, the higher will be the prices.

12 And as I said, that it's not just the high market
13 concentration, but also the fact that the other top-two PBMs
14 are owned by health plans themselves, which are competing
15 with WellCare.

16 So by going to these other two top PBMs, you
17 really haven't solved the problem of input foreclosure.
18 They will still -- Optum would have the same incentives to
19 not provide the same quality service to WellCare as it
20 provides to its own UnitedHealth plans which are competing
21 with WellCare.

22 So by going to these two other top PBMs, you
23 really haven't solved the problem.

24 Q Even if CVS were to lose WellCare as a customer
25 because the pricing or the service were just not as good as

1 WellCare wanted, could that still be a profitable strategy
2 for CVS?

3 A It could be.

4 So let's think about the economics of it or how
5 the math would work out.

6 So suppose you're CVS and you know that if you
7 provide poor service to WellCare, there is some probability
8 that you will lose WellCare as a customer, and so why --
9 basically, that probability times the profit per customer is
10 what you will lose.

11 So in the PBM industry, the net margins are about
12 in the 2 percent range.

13 So if a customer is spending \$100 on a
14 prescription drug, just hypothetically, and you lose that
15 customer as a PBM customer, you're going to lose \$2.

16 If, now, as a result of doing this input
17 foreclosure, you could also gain a customer for the CVS PDP
18 and if you gain a customer for the CVS PDP, you provide PBM
19 services to this customer, so you're going to get your \$2
20 back; and, in addition, you're going to make a profit on the
21 PDP side of the market. So that's roughly another \$3.

22 And in addition, if the customer goes to a
23 CVS/Pharmacy, you're going to make a profit on the pharmacy
24 side of the market. That's an additional \$3.

25 So what'll happen is that losing one PBM customer

1 is roughly \$2, but gaining that same customer back as a
2 pharmacy PBM and health plan customer is roughly \$9 extra in
3 profit.

4 So each integrated customer is roughly four times
5 as profitable as just a PBM customer.

6 THE COURT: I have a question about that analysis
7 you just went through.

8 THE WITNESS: Yes, sir.

9 THE COURT: I recall in your materials, Doctor,
10 that breakdown that you just alluded to of the \$100 -- for
11 every \$100 of -- spent for -- by an insured customer, you
12 did a breakdown that had 58 of the 100 going to the
13 manufacturer and 42 going to the middlemen --

14 THE WITNESS: Yes.

15 THE COURT: -- right?

16 The PBM got \$5, in your breakdown?

17 THE WITNESS: Yes.

18 THE COURT: The pharmacy got 15 out of the 100?

19 THE WITNESS: Yes.

20 THE COURT: The wholesaler got \$2?

21 THE WITNESS: Yes.

22 THE COURT: But the thing that caught my eye the
23 most was the insurer was getting 19?

24 THE WITNESS: Yes.

25 THE COURT: That confused me, and I want you to

1 help me clear that up in my mind.

2 The insurer, the person -- remember now, this is
3 \$100 spent by an insured customer?

4 THE WITNESS: Yes.

5 THE COURT: The insurer is already paying monthly
6 for his health insurance plan or her health insurance plan,
7 right?

8 THE WITNESS: Uh-huh.

9 THE COURT: So how is the 19 -- they've already
10 paid that. How can another \$19 be going to the insurer when
11 they've already been paid the monthly fee?

12 THE WITNESS: So basically what that estimate is
13 that, suppose I pay my \$100 in premiums to an insurer.

14 And if I look at the financial statements of
15 insurers, what they say is they spend roughly \$81 out of
16 those \$100 on reimbursing my healthcare expenditures, and
17 the remaining \$19 they keep either as profit or
18 administrative costs or marketing expenses.

19 So that \$19 reflects basically the fraction of the
20 premium that is not going towards healthcare but is going
21 towards some other insurer function.

22 THE COURT: So when you say \$100 spent by an
23 insured customer on pharmaceutical products, you're not
24 talking about the \$100 they spent at the pharmacy itself?

25 THE WITNESS: No. Yeah.

1 THE COURT: No.

2 It's a more --

3 THE WITNESS: Holistic.

4 THE COURT: -- more holistic approach.

5 THE WITNESS: Holistic, exactly.

6 THE COURT: Thank you for clarifying that.

7 BY MR. QUILLEN:

8 Q And in your opinion, does CVS have the ability to
9 use its pharmacy network to disadvantage its competitors if
10 it wanted to?

11 A Yes, I do.

12 So CVS's own financial statements say that among
13 the top 100 pharmacy markets in the U.S., they are the No. 1
14 or No. 2 company in 93 out of those top 100 markets. So
15 they're saying we're No. 1 or No. 2 in 93 out of the top
16 100 markets.

17 So now, if you are -- you know, if you think about
18 the incentives of CVS, pharmacy, they could basically say,
19 we're not going to provide competitive rates to health plans
20 in these markets, and these health plans will not have much
21 option, because CVS is a dominant or the No. 1 or No. 2
22 pharmacy in these markets so --

23 THE COURT: So this is what the PBM would be
24 saying, CVS PBM?

25 THE WITNESS: Yes, CVS PBM or CVS/Pharmacy itself.

1 THE COURT: Okay.

2 THE WITNESS: So CVS/Pharmacy would say: We're
3 not giving a big discount to a health plan that's competing
4 with CVS.

5 So like when -- and you're right that there will
6 be a PBM on part of the health plan that will be negotiating
7 with CVS the pharmacy.

8 But basically the CVS/Pharmacy has less of an
9 incentive to give a price discount to a competing health
10 plan versus to its own health plan, because if they give a
11 price discount to a competing health plan, that takes away
12 market share from the CVS health plan.

13 And if they are the No. 1 or No. 2 pharmacy in
14 that market, they're kind of like a must-have pharmacy. So
15 a competing health plan will just have to accept the higher
16 rate, rather than say, I'm not dealing with CVS, I'm going
17 to contract with other pharmacies.

18 But in markets where CVS is not the No. 1 or
19 No. 2, then that incentive is not there because you can
20 always say there are -- there's enough competition there to
21 contract with other pharmacies.

22 BY MR. QUILLEN:

23 Q And in your opinion, if the net price to the plan
24 of prescription drugs went up, all things being equal, would
25 premiums go up, too?

1 A Yes.

2 So as prices go up, premiums would go up, because
3 premiums are used to cover healthcare expenditures. So if
4 that underlying cost is going up, your premiums are going to
5 go up.

6 Q I'd like to talk about something you mentioned
7 earlier: The increasing concentration in the PDP market.
8 Can you say a little bit more about that, please?

9 A Sure.

10 So analysis done by Professor Richard Scheffler,
11 using publicly available data on PDP enrollment in these
12 34 different geographic markets, shows that from 2009 to
13 2018, the Herfindahl Index increases by 342 points, or
14 23 percent.

15 Q And can you say what is -- what is the
16 Herfindahl Index and why is it important here?

17 A Yeah. Sure.

18 THE COURT: Yeah. We don't deal with that every
19 day around here.

20 THE WITNESS: The Herfindahl Index is a well-known
21 and the most commonly used measure of market concentration.

22 And economists typically believe that the higher
23 the Herfindahl Index, the higher the prices would be in the
24 market.

25 And the DOJ/FTC have guidelines which are based on

1 the Herfindahl Index on whether they think the market is
2 moderately concentrated or highly concentrated.

3 THE COURT: And the -- correct me if I'm wrong
4 now:

5 Now, the importance of that analysis with regard
6 to the higher the prices is that in order to determine the
7 public interest in any transaction going forward, the
8 Department of Justice and the Courts, ultimately, have got
9 to decide whether or not it's likely to cause prices to go
10 up or down.

11 THE WITNESS: Yes, sir.

12 THE COURT: Because if they're likely to go up,
13 it's not going to be in the public interest. And if it's
14 going to be less available, it's not going to be in the
15 public interest.

16 So both Justice and the Courts are trying to
17 figure out price -- I mean, the likely consequences to the
18 pricing of the product, right?

19 THE WITNESS: Yes.

20 So basically what the -- you're absolutely right.

21 And basically what the publicly available
22 enrollment data shows, that not only did the
23 Herfindahl Index go up by 342 points over this period, which
24 is substantial -- so, for example, the DOJ/FTC guidelines
25 consider a 100-unit increase in the Herfindahl Index that

1 leads to a moderately concentrated market as raising
2 significant competitive concerns.

3 MR. QUILLEN: And there's a demonstrative slide --
4 if the Court would like to look at it, No. 17 --

5 THE COURT: 17.

6 MR. QUILLEN: -- that lays out the various
7 categories from the DOJ and FTC guidelines that are used in
8 horizontal merger cases to determine what level of concern
9 one should have about increased concentration in a market.

10 THE COURT: That is -- now, does counsel have a
11 copy of these, opposing counsel?

12 MR. QUILLEN: Yes.

13 THE COURT: Okay.

14 All right. I have 17 here.

15 MR. QUILLEN: Okay.

16 THE WITNESS: So basically, slide 17 shows how the
17 DOJ/FTC guidelines treat changes in Herfindahl Index and
18 post-merger Herfindahl Index.

19 So if the Herfindahl Index is less than 1500 and
20 the change in the Herfindahl Index as a result of a merger
21 is less than 100, then there's no challenge or no concern.

22 If the change in the Herfindahl Index is greater
23 than 100 and the Herfindahl index after a merger is between
24 1500 and 2500, then that raises significant competitive
25 concerns.

1 If the Herfindahl Index is between -- the change
2 in index is between 100 and 200, and after the merger the
3 market becomes highly concentrated, which is the
4 Herfindahl Index exceeds 2500, again, there is significant
5 competitive concern.

6 And the -- kind of the most severe case is where
7 the Herfindahl Index increases by 200 and the market is
8 highly concentrated as a result of the merger. So
9 post-merger, the Herfindahl Index is greater than 2500.

10 In that case, the guidelines say that the merger
11 is presumed likely to enhance market power. And it can only
12 be or it should be -- it could be reverted by evidence that
13 maybe, say, entry in the market or some other thing would
14 reduce the Herfindahl Index.

15 THE COURT: Okay.

16 THE WITNESS: So going back to kind of the trends
17 in the Herfindahl Index, Herfindahl Index in each one, on
18 average, increase by 342 points. So you can see much higher
19 than the FTC DOJ threshold.

20 And in 2018, all markets were moderately
21 concentrated, which means their Herfindahl Index exceeded
22 1500. And there were two markets which were highly
23 concentrated, which means their Herfindahl Index exceeded
24 2500.

25 So this transaction is happening in a market that

1 is experiencing significant increases in Herfindahl Index
2 already, and that already is either moderately concentrated
3 or highly concentrated.

4 There's a paper by Princeton researcher
5 Anna Charney. And what she and her colleagues did is, they
6 looked at data from 2006 to 2012. And what they find is
7 that in every year from 2006 to 2012, roughly 15 percent of
8 the plans in the PDP market were involved in a merger.

9 In fact, they say that during this time period,
10 nearly every major PDP insurer has been involved in a
11 merger.

12 So one of the reasons why the Herfindahl Index has
13 been increasing over time is because of mergers in these
14 markets.

15 The other thing they say is during the same time
16 period, 2006 to 2012, there was basically no entry of health
17 plans after the first two periods.

18 So after 2006 and 2007, they find little or no
19 entry of health plans in these markets.

20 So there are mergers happening. There is no entry
21 happening.

22 And what they find is that during the same time
23 period, premiums increased by 41 percent in nominal terms,
24 and about 26 percent inflation adjusted.

25 They also find that drug coverage fell down by

1 about 29 percent.

2 And out-of-pocket costs for consumers for the most
3 popular drugs doubled.

4 So you basically have a market with rising
5 concentration during this time period, mergers, no entry,
6 high premiums, and declining coverage or higher
7 out-of-pocket costs for customers.

8 And if you look at what the evidence says on the
9 effects of mergers in these markets or the effect of
10 concentration in these markets, there are three studies that
11 have directly looked at the effects of competition or
12 mergers in the PDP market.

13 The first paper is by the Congressional Budget
14 Office. They have a working paper where what they did was
15 they compared markets where the number of competitors was
16 changing over time, relative to markets where the number of
17 competitors was not changing over time.

18 And what they find is that markets in which the
19 number of competitors or forms is changing over time, those
20 markets have lower premium growth, compared to markets where
21 the number of competitors is constant.

22 So basically what they say is increase in the
23 number of firms in the market leads to lower premiums.

24 So a merger will reduce the number of firms in the
25 market and, therefore, will lead to higher premiums.

1 There's another study by the Princeton
2 researchers, the same study I mentioned earlier. What they
3 do is they explicitly look at mergers in these markets.

4 So the third experiment is compare two plans which
5 are operating in the same market. One plan merges and the
6 other plan, which is operating in the same market, doesn't
7 merge.

8 The plan that merges, it sees a premium growth --
9 a premium change over time 7 percent more than the plan that
10 does not merge.

11 So they're basically saying, Look, when plans
12 merge, that leads to about a 7 percent increase in premiums
13 as a result of the merger, because any other thing that's
14 happening in this market is controlled for by looking at
15 premium trends for these plans that did not merge and that
16 were exactly in the same market.

17 A third approach is a paper by Wharton Professor
18 Claudio Lucarelli, and he took a different approach. So he
19 took what economists call a structural approach.

20 So what he did is he says, I'm going to come up
21 with a model of how consumers behave in this market, how
22 they choose plans, what plan features matter most to
23 consumers.

24 Then I'm also going to create a model of how firms
25 behave in this market and compete with each other.

1 And then I'm going to use existing data from the
2 market, the market share of firms, the features of different
3 plans, to calibrate this model, to calibrate how consumers
4 and firms actually behave or to find out what the parameters
5 of these models are.

6 And once you have done that, you can now run
7 what-if scenarios. So you can say, What would happen if
8 Firm A merged with Firm B in this market?

9 And that's what they did.

10 So they looked at the merger of two companies in
11 this market, and that predicted that premiums of the merged
12 firms would go up by 4.7 percent.

13 And actually, premiums of firms that do not merge,
14 they also go up by roughly 1 percent or 0.9 percent. The
15 reasoning is that now they know the market is more
16 concentrated, and that results even rival firms to increase
17 their prices.

18 So in some sense, all three studies reach the same
19 conclusion, even though they take very different approaches.

20 One approach is at the market level. The other is
21 at the plan level. The third one is the structural model.
22 All three of them reach the same conclusion, which is that
23 mergers lead to an increase in concentration and lead to
24 higher premiums.

25 And as you had mentioned earlier, what happens to

1 premiums is a key question for public interest.

2 So all three studies which have looked at the PDP
3 market have the same qualitative conclusion: That loss of
4 competition in the market or mergers in these markets lead
5 to increases in premiums.

6 BY MR. QUILLEN:

7 Q Are you aware of any studies as reputable or
8 widely cited as these that come to the opposite conclusion?

9 A I'm not.

10 These are the only three studies I'm aware on the
11 PDP market.

12 Q And how do the results of the empirical analyses
13 in these papers compare to what you would expect as a
14 theoretical matter as an economist?

15 A So the empirical evidence from these three papers
16 is consistent with economic theory.

17 So, again, there are different -- these papers
18 have used different approaches to theoretically model this
19 market.

20 So you can use option theory, where firms are --
21 that's where they're trying to mimick the institutional
22 details of this market, where firms submit bids and then the
23 plan with the lowest bid will attract more customers.

24 You can use traditional model like the Bertrand
25 model, where firms are competing on prices; or another

1 traditional model called the Cournot model, where firms are
2 competing on quantity.

3 But, ultimately, it doesn't matter what model you
4 use. All three models predict the same thing: That the
5 loss of a competitor from a market will result in higher
6 premiums.

7 And the merger and divestiture does result in a
8 loss of competitor. So Aetna will no longer be in the
9 market, whether the divestiture happens or not, because
10 Aetna is out of the market, irrespective of the divestiture
11 happened.

12 So, basically, all three theoretical models would
13 also predict that this merger and divestiture together will
14 raise premiums.

15 Q I understand that you've done some calculations of
16 the concentration in the market after the divestiture under
17 some various assumptions about how much of Aetna's former
18 business WellCare could keep.

19 And I think slide 18 will actually be useful to
20 look at for purposes of this discussion.

21 A Actually --

22 Q Can you explain slide 18 there?

23 A Sure.

24 If I have the permission, I would like to start
25 with slide 16 --

1 Q Sure.

2 A -- because -- and I apologize for the math, but
3 I think that's --

4 THE COURT: Well, that's your line of business.

5 THE WITNESS: That will help explain slide 18
6 better.

7 So what this does is you're calculating this
8 Herfindahl Index, that is, this measure of market
9 concentration.

10 And pre-merger, I'm treating Aetna, CVS, and
11 WellCare as separate entities. So the three of them are
12 competing with each other in these markets.

13 So, in fact, in all 34 markets, Aetna, CVS, and
14 WellCare pre-merger were competing with each other.

15 Post-merger and divestiture, what'll happen is
16 some of Aetna's consumers will be assigned to WellCare,
17 right? Because we've sold Aetna's PDP business now to
18 WellCare.

19 But not all of these consumers are going to stay
20 with WellCare. The next open enrollment, some of them might
21 move back to CVS.

22 So the fraction of Aetna's consumers that CVS can
23 control is what I call the retention rate, and that is going
24 to determine how the Herfindahl Index changes in this
25 market.

1 So now, if you go to slide 18.

2 So this shows how this mathematical formula works
3 in the Kansas market.

4 So let's start with the assumption that WellCare
5 has the ability to retain 100 percent of Aetna's consumers
6 with itself. So none of these consumers go back in the next
7 open enrollment to CVS.

8 In that scenario, if you look at the bottom
9 right-hand corner, the Herfindahl Index would increase by
10 95 points, and the post-merger divestiture Herfindahl Index
11 would be 2,140.

12 So since 95 is just below that 100 threshold,
13 there's no significant concern.

14 But if I relax the assumption of 100 percent
15 retention just a little bit, so now I say only 90 percent of
16 Aetna's consumers will stick with WellCare but 10 percent
17 will move back to CVS.

18 So even under the assumption that only 10 percent
19 of WellCare's -- of Aetna's consumers move back to CVS, now
20 the Herfindahl Index rises by 120 points.

21 And the post-merger or post-divestiture
22 Herfindahl Index is 2,165.

23 So according to the DOJ/FTC guidelines, that would
24 be significant competitive concerns.

25 And so if you imagine that WellCare is not a

1 strong plan, cannot compete aggressively with CVS, then you
2 might have scenarios where WellCare is able to retain, say,
3 only 50 percent of the consumers.

4 So if that happens, if you look at 50 percent, the
5 Herfindahl Index rises by 282 points. So that is
6 significantly above the 100 threshold. And the market is
7 approaching becoming highly concentrated. The
8 Herfindahl Index post divestiture is 2,327.

9 And, finally, if you take the last two scenarios,
10 which is, suppose WellCare can only retain 20 percent of
11 Aetna's consumers. In that scenario, the Herfindahl Index
12 rises by 468 points. So way above the 100 or 200 threshold
13 in the DOJ/FTC guidelines, and the market now becomes highly
14 concentrated.

15 So this is a scenario where there's a presumption
16 of increase in market power.

17 And the same holds for the 10 percent scenario and
18 the zero percent scenario.

19 So what this shows is what other prediction is
20 about how strongly can WellCare compete with CVS and how
21 many of these customers can they actually retain versus how
22 many of them will be lost is critical in understanding what
23 will happen to the Herfindahl Index and, in that sense, in
24 understanding whether this transaction is in the public
25 interest or what will happen to premiums and will this

1 transaction raise significant competitive concerns.

2 So if you go to the exhibit on slide 19, what
3 I did was I repeated the analysis I did for Kansas for all
4 markets, all 34 markets.

5 So the first row here shows what I think is the
6 best-case scenario, which is that after the divestiture,
7 Aetna consumers go to WellCare. Somehow, they love WellCare
8 and they don't ever want to leave it. And so WellCare is
9 able to retain 100 percent of these Aetna consumers.

10 Even in that scenario, there are 7 out of those 34
11 markets where there would be significant competitive
12 concerns.

13 So now let's relax this assumption a little bit.
14 So let's say, no, maybe some -- these were consumers who
15 chose Aetna plans, right? Like they had a choice to choose
16 between WellCare and Aetna, but they chose to go with an
17 Aetna plan. So now when they find out that they're actually
18 no longer in an Aetna plan, they actually belong to
19 WellCare, some of them would want to move back.

20 So let's assume 25 percent of them move back.

21 THE COURT: That's -- a typical contract is, what,
22 two years or one year?

23 THE WITNESS: One year.

24 THE COURT: One year.

25 THE WITNESS: One year.

1 BY MR. QUILLEN:

2 Q And can you say something about the branding of
3 those plans now and over the next couple of years?

4 A Yes.

5 So my understanding is that for the first year,
6 for 2019, WellCare can use Aetna's brand.

7 So for the first year, maybe consumers don't know.
8 They think -- they still think they're in Aetna.

9 In the next year, they cannot use the brand, so
10 they'll have to tell the consumers: You are in WellCare.
11 So some of them might want to move to CVS.

12 But in the next year, CVS cannot use the Aetna
13 brand but people would still know that CVS and Aetna have
14 merged.

15 And the year after that, they can reintroduce the
16 Aetna brand.

17 So then you can have even a greater exodus of
18 people who like Aetna wanting to move back to an Aetna
19 brand, right?

20 So I think the scenario where, say, I think it's
21 still optimistic that 75 percent of the customers still
22 remain with WellCare, but 25 percent decide to move to CVS
23 or Aetna combined.

24 And in that scenario, what happens is that the
25 number of markets with competitive concerns triples. So

1 instead of seven markets where there are significant
2 competitive concerns, now we have 21 markets with
3 significant competitive concerns and one market where there
4 is actually a presumption of increase in market power.

5 And now if you take the scenario further, so now
6 we say, let's do it 50/50, I don't know, 50 percent is a
7 good number.

8 So Aetna retains 50 -- or WellCare retains
9 50 percent of Aetna's consumers, but 50 percent decide to go
10 back to CVS. In that scenario, 30 out of the 34 markets
11 have significant competitive concerns, and one market has a
12 presumption of increase in market power.

13 So, again, this analysis shows that the key factor
14 or one of the key factors in helping figure out whether this
15 divestiture raises significant competitive concerns is to
16 understand WellCare's ability to hold on -- to compete with
17 CVS and Aetna and to hold on to these Aetna customers that
18 were divested to them.

19 THE COURT: And who's WellCare using, in this
20 first year anyway, as its PBM manager?

21 THE WITNESS: It is CVS.

22 So -- and that is a very good question, which
23 leads to their ability to compete with CVS.

24 If one of the key inputs that are -- to you, are
25 being provided by your competitor, your ability to compete

1 with CVS would be limited.

2 Another factor which I think -- which says that
3 they will not be able to retain a lot of these customers, is
4 if you look at the price at which WellCare bought Aetna's
5 PDP assets.

6 So let's start with the original transaction. CVS
7 bought Aetna for \$69 billion. Aetna's profits are, I think,
8 in the 4.2 or \$4.6 billion range. So they bought Aetna for
9 16 times their profits per year.

10 And so you would ask: Why are you buying someone
11 for 16 times profits per year? Because now you own the
12 company. You're not only going to enjoy these profits one
13 year, you're going to enjoy these profits every year from so
14 on.

15 So if you take the present value of all the future
16 profit stream, it seems reasonable to pay 16 times profit,
17 right?

18 So now WellCare bought Aetna's PDP assets,
19 according to their financial statements, for about
20 \$107 million.

21 So if you take the same multiple of 16, this
22 translates that WellCare expects profits from Aetna's PDP
23 business to be in the 6 million or \$6.7 million range.

24 So you would ask, like -- so remember, we noted
25 that Aetna has 2.2 million PDP subscribers. So you're

1 basically saying, 2.2 million PDP subscribers are only going
2 to generate 6.7 million in profit. That's \$3 of profits per
3 consumers. That is way too low.

4 So I think the reason they bought it at such a low
5 price is because they know they wouldn't be able to retain
6 these profits -- these customers.

7 So they know that all the 2.2 million customers
8 are not going to be generating profit for them year after
9 year, and that's -- because otherwise, another way to look
10 at this is, say these 2.2 million customers on average, they
11 spend about \$2,000 a year on prescription drugs, so the
12 premiums for these customers are about \$2,000 a year. So
13 that's 4.4 billion in revenues. You're going to -- if you
14 expect 4.4 billion in revenues every year, you wouldn't buy
15 that asset for 100 million. That 100 million is a very low
16 price.

17 And one way -- so it's consistent with this notion
18 that WellCare knows that a lot of these 2.2 million
19 customers are going to be lost, and that's why they're not
20 willing to pay more than \$107 million for this asset. So
21 that's one explanation for it.

22 Another potential explanation for this is that
23 maybe there was no one else who wanted to buy these assets,
24 so WellCare was the only company and they got a good
25 bargain.

1 But I think that is still concerning, because that
2 says there's no potential entry in this market; that you are
3 getting this great business and no one wanted -- came -- no
4 one wanted to step up and enter this market. And so to me,
5 that says that the potential for the -- there are
6 significant entry barriers.

7 So whichever way you look at this transaction
8 price, I think it raises significant competitive concerns.
9 Either it means that this business is not going to stay
10 viable and they're going to lose a lot of the Aetna
11 customers or it means that there's no potential entry in
12 this market, and I think both are concerning.

13 BY MR. QUILLEN:

14 Q Well, let's take your best-case scenario.

15 Let's say, despite all the disadvantages you've
16 talked about, WellCare is able to hold on to every single
17 Aetna customer that it acquired. Are there still regions of
18 the country where you would have potentially significant
19 competitive concerns nonetheless?

20 A Yes.

21 So if you look at Exhibit 20 or slide 20, I have
22 listed seven regions where there would still be significant
23 competitive concerns.

24 So just to give an example, the first region is
25 Mississippi. There, the prediction is that in this

1 best-case scenario, where they are able to retain
2 100 percent of Aetna customers, which I think is unlikely,
3 but even in that scenario, the Herfindahl Index arises by
4 230 points, the post-divestiture Herfindahl Index is 2,200,
5 so the market is moderately concentrated, and WellCare's
6 market share would be 21 percent, CVS's market share would
7 be 31 percent.

8 Q And if you have a market where the
9 Herfindahl Index rises that much and is moderately
10 concentrated, if there's no real possibility of significant
11 entry, what would you expect to happen to premiums?

12 A I would expect premiums to go up. And I think
13 that would be consistent with the DOJ/FTC guidelines.

14 Q Is it consistent with the empirical literature you
15 were just talking about as well?

16 A It is consistent with the empirical literature, as
17 well as the theoretical literature.

18 Q Let's go beyond the best-case scenario.

19 Let's say that this new transaction makes WellCare
20 such a fantastic competitor that it cannot only retain its
21 Aetna subscribers but start taking market share from other
22 larger competitors.

23 A Sure.

24 Q Is it possible that that could alleviate the
25 concerns about concentration in these markets?

1 A So let's focus on Mississippi again, the first
2 row.

3 And what we see is WellCare has, after the
4 divestiture, a market share of 21 percent in Mississippi,
5 and CVS has a market share of 31 percent.

6 So if you take some of CVS's customers and give
7 them to WellCare, the market will become less concentrated,
8 right?

9 And that is a scenario I have shown on the next
10 exhibit, which is slide 21, in the last row.

11 So now what happens is WellCare starts taking
12 customers away from CVS till their market share is
13 equalized. So each now controls 26 percent of the market.

14 So even in this numerical scenario, where not only
15 are they retaining 100 percent of Aetna's consumers, now
16 they're actually getting consumers from CVS also, despite,
17 as you said, CVS providing the key input to WellCare.

18 But even in this Goldilocks scenario, what we find
19 is that the change in Herfindahl Index is 180, and --

20 THE COURT: Let me ask you to stop there a second.

21 THE WITNESS: Yes, sir.

22 THE COURT: The analysis that you've been doing
23 and the studies you've been alluding to, do any of them
24 discuss the likely, in this kind of scenario, the likely
25 conduct that the CVS PBM will engage in if all of a sudden

1 WellCare is taking away its customers in the PDP arena?

2 THE WITNESS: Yes.

3 THE COURT: Would they stop being their PBM
4 manager because it would be contrary to the interests of
5 their PDP business? Or do they do an analysis on that? Or
6 have you done any analysis of that?

7 THE WITNESS: Yeah.

8 So I do discuss that.

9 And basically, this, again, comes back to the
10 original point of input foreclosure.

11 So basically if WellCare starts taking away PDP
12 business from CVS, CVS, the PBM, has an incentive to
13 disadvantage WellCare.

14 So they could disadvantage them by not passing on
15 all the rebates they're getting from the manufacturer back
16 to WellCare. They could disadvantage them by not
17 negotiating hard with pharmacies. They could disadvantage
18 them by increasing the administrative costs for WellCare.

19 THE COURT: Could they require that the customers
20 only get their pharmaceutical drugs at CVS/Pharmacies and
21 they can't go to any other pharmacy? Could they do that?

22 THE WITNESS: I'm not sure of that.

23 So I think they can advantage CVS/Pharmacies in
24 several ways.

25 THE COURT: Like a bigger co-pay?

1 THE WITNESS: Yeah.

2 THE COURT: Excuse me. A smaller co-pay.

3 THE WITNESS: A smaller co-pay.

4 THE COURT: Smaller.

5 THE WITNESS: Or advertising the CVS brand more.

6 But I don't know if they can prohibit you from --

7 I think that would be a very restrictive --

8 THE COURT: Yeah.

9 THE WITNESS: -- pharmacy network if you just say,
10 You can only get your drugs from CVS and nowhere else.
11 I think, you know, a lot of consumers would be up in arms
12 about that, and that is probably one of the reasons that
13 might not happen.

14 THE COURT: No.

15 THE WITNESS: And you're right. In the end, they
16 could also -- if they think they're losing a lot of
17 market share, they might decide to not provide PBM services
18 to WellCare.

19 THE COURT: Don't make a bid?

20 THE WITNESS: Yeah.

21 So that is a possibility.

22 BY MR. QUILLEN:

23 Q And looking at what you have done on slide 21,
24 then, would it be accurate to say that there are four
25 markets in which it's mathematically impossible to get the

1 increase in concentration back below a level of concern just
2 by virtue of WellCare increasing its market share against
3 CVS?

4 A Yes, that is accurate.

5 Q And two of those rows are in bold. Can you
6 explain why those are in bold?

7 A So in two of those rows, now, what happens is that
8 WellCare has the highest market share, which means even if
9 it takes customers from other competitors in this market,
10 that would only increase the Herfindahl Index.

11 So in this scenario, it's basically, you cannot
12 have the Herfindahl Index going down anymore.

13 So the best, best-case scenario in these markets
14 is still the Herfindahl Index rising by more than 100 points
15 and the post-divestiture index being above the 1500
16 threshold.

17 So the best, best-case scenario in this market
18 still raises significant competitive concerns; that no
19 matter how strong WellCare becomes, you would still have
20 significant competitive concerns, according to the
21 DOJ/FTC guidelines.

22 BY MR. QUILLEN:

23 Q And in those -- those markets, Arkansas,
24 Mississippi, that means that even if WellCare could somehow
25 take market share from any competitor it wanted in such a

1 way that it was making the Herfindahl Index as low as
2 mathematically possible, it would still be above levels of
3 concern?

4 A Yes, sir.

5 Q Are there concerns, like the ones we've just been
6 discussing, specifically with respect to low-income
7 enrollees?

8 A They are.

9 So the DOJ, in its competitive impact statement,
10 it said that in 9 regions, the merged company will account
11 for between 35 percent and 55 percent of all low-income,
12 subsidy-eligible beneficiaries.

13 So this was after the merger but with no
14 divestiture.

15 So now, given the divestiture, some of these
16 problems still remain.

17 So in two markets, WellCare will account for more
18 than 35 percent of the low-income, subsidy beneficiaries.

19 So this original concern that DOJ raised is not
20 fully solved by the divestiture.

21 THE COURT: That's Arkansas and Hawaii?

22 THE WITNESS: That's Arkansas and Hawaii. You're
23 correct.

24 BY MR. QUILLEN:

25 Q What are your expectations of WellCare's abilities

1 as a competitor going forward versus Aetna's ability to
2 compete before the merger?

3 A Sure.

4 So I think WellCare is a much weaker competitor
5 than Aetna, and I have three reasons to think that.

6 First is, Aetna has a much stronger brand than
7 WellCare. So when customers were given a choice to choose
8 between a WellCare plan and an Aetna plan, more customers
9 chose Aetna compared to WellCare.

10 The second is that Aetna is -- as you said, it has
11 2.2 million beneficiaries in the PDP market, but it is a
12 much bigger insurer. It is -- overall, it has about
13 20 million --

14 THE COURT: 21 million.

15 THE WITNESS: -- subscribers.

16 So that gives it more clout when it's negotiating
17 with pharmacies and when it's negotiating with
18 manufacturers, which WellCare doesn't have.

19 So I think that bigger sizes allows economies of
20 scale better bargaining power for Aetna compared to
21 WellCare.

22 And that is also evident from what has happened in
23 this market.

24 As I mentioned earlier, Aetna has been able to
25 increase its market share from 2 percent to 9 percent before

1 the transaction, and WellCare wasn't able to increase their
2 market share so dramatically.

3 So all these three factors kind of say that
4 WellCare was a much stronger competitor than -- sorry.
5 Aetna was a much stronger competitor than WellCare.

6 THE COURT: In the PDP arena or in general?

7 THE WITNESS: I'm talking specifically in the PDP
8 arena.

9 But it could apply more generally. I haven't
10 looked at it.

11 THE COURT: Okay.

12 BY MR. QUILLEN:

13 Q And I know we've touched on this a couple of times
14 so far; but to put a finer point on it, what are your views
15 on the likelihood that entry into the PDP market will
16 alleviate some of the competitive concerns we have been
17 discussing?

18 A So I think there are significant barriers to entry
19 in this market.

20 And I have in one of the exhibits a statement by
21 the DOJ, where they basically agree or I agree with their
22 assessment. That's slide 32.

23 And where they state that "Neither entry nor
24 expansion is likely to solve the competitive problems
25 created by this merger between CVS and Aetna. Recent

1 entrants into the individual PDP market have been largely
2 unsuccessful, with many subsequently exiting the market or
3 shrinking their geographic footprint.

4 "The effective entry into the sale of PDPs
5 requires years of planning --

6 THE COURT: Slow down a little bit. My reporter,
7 he's very good, but you're going pretty fast there.

8 THE WITNESS: Okay.

9 "Effective entry" -- is that fine?

10 COURT REPORTER: Yes.

11 THE WITNESS: "Effective entry into the sale of
12 individual PDPs requires years of planning, millions of
13 dollars, access to qualified personnel, and competitive
14 contracts with pharmacies and pharmaceutical manufacturers."

15 Because of these barriers to entry, entry or
16 expansion into the sale of individual PDPs is unlikely to be
17 timely or sufficient to remedy then anti-competitive effects
18 from this merger.

19 And as I said, the paper by the Princeton
20 researchers also found that after the first two years, there
21 was not -- there wasn't any entry into this market.

22 So I think the structure of this market, as well
23 as past experience, are consistent with significant entry
24 barriers.

1 BY MR. QUILLEN:

2 Q So when you see an increase in concentration in
3 this market, do you have any reason to believe that it would
4 not lead to an increase in premiums?

5 A I don't have any reason to believe that it will
6 not lead to an increase in premiums.

7 Or to state it another way, you know, the analysis
8 shows that in several markets, if WellCare is unable to
9 aggressively compete with CVS, there would be significant
10 competitive concerns, and those competitive concerns would
11 not be mitigated by entry into these markets.

12 Q I'd like to talk about some of the arguments about
13 the efficiencies that this transaction might create.

14 Before I do, is there anything else you wanted to
15 say about the PDP market specifically?

16 A I think -- I would just like to summarize the main
17 points so far, which is that, first, we have to remember
18 that the public in this PDP market are Medicare
19 beneficiaries. They are older. They are low income. They
20 have multiple health conditions.

21 So this is not like a luxury car market where
22 prices go up and we can argue whether the public would be
23 hurt or not. The public here is really vulnerable. So if
24 premiums go up, that will have a big impact on consumers in
25 this market.

1 The second point I want to summarize is that the
2 numbers show that, you know, no matter what scenario you
3 assume, there are always some markets where there will be
4 significant competitive concerns, which is, no matter how
5 strong WellCare gets, there are still some markets where
6 significant competitive concerns raised -- are there.

7 My expectation is that the competitive concerns
8 will not only remain in those two markets but in many more
9 markets because I don't think WellCare is a strong
10 competitor relative to CVS or Aetna. They don't have the
11 same brand. They get PBM services from CVS itself. They
12 don't have the same economies.

13 The third thing is the empirical evidence here is
14 clear; that a loss of a competitor such as Aetna or loss of
15 any competitor raises premiums in these markets. And that's
16 consistent with both theory and empirical evidence.

17 So I think the potential for harm here is real.

18 Q Are you aware of any efficiencies that this merger
19 and divestiture might create in the PDP market specifically?

20 A No.

21 And I think the reason for that is so if you look
22 at the combined transaction, the merger and the divestiture,
23 this is not now a merger in the PDP market, right, because
24 Aetna's assets have now been divested to WellCare.

25 So Aetna and CVS are actually not merging in the

1 PDP market, which means there cannot be any PDP-specific
2 efficiencies because there is no PDP-specific merger here.

3 And even if you now relax the scenario, so suppose
4 you say the divestiture doesn't happen and now there is a
5 merger in the PDP market, so Aetna and CVS merge in the PDP
6 market, the DOJ, in its own assessment of this merger, has
7 noted that they did not -- and, you know, I have the exact
8 quote -- but they did not find merger-specific, verifiable
9 efficiencies that would outweigh the competitive concerns.

10 So the DOJ agrees that even if there was a
11 PDP-specific merger, there are no merger-specific -- or the
12 merger-specific efficiencies are unlikely to outweigh the
13 competitive concerns.

14 But I think the more important point is that there
15 is no PDP-specific merger between CVS and Aetna and the PDP
16 market.

17 THE COURT: So in assessing whether or not this
18 merger, as currently constituted, with the divestiture --

19 THE WITNESS: Yes.

20 THE COURT: -- in assessing whether or not the
21 merger as currently constituted is in the public interest or
22 not -- which is my job, right?

23 THE WITNESS: Yes.

24 THE COURT: -- should I limit myself to the impact
25 on the PDP market alone? Or should I look to the broader

1 sense of how the entities that have merged here are going to
2 impact the greater market, the non-PDP market?

3 THE WITNESS: That is a very loaded question.

4 THE COURT: Well, give it your best shot.

5 THE WITNESS: So, you know, in my earlier
6 testimony, I've said that the merger raises competitive
7 concerns in other markets also.

8 So from my personal point of view, you know,
9 those -- there are competitive concerns in those other
10 markets.

11 I don't understand the law as well as most people
12 in this room. So I don't know -- but I think the merger --
13 so if you're asking me for my assessment that -- would the
14 public be affected in these other markets as a result of
15 these mergers?

16 Yes, they would be.

17 THE COURT: Well, when the Justice Department
18 filed its complaint opposing the merger prior to the
19 divestiture remedy, they were saying it was broader than
20 just the PDP market, weren't they?

21 THE WITNESS: I'm not sure.

22 My understanding is that their complaint was
23 limited to the PDP market, and they downplayed the vertical
24 concerns in the other markets. They didn't think they were
25 significant enough.

1 THE COURT: Do you see the efficiencies in the
2 other market here? Do you see efficiencies?

3 THE WITNESS: So there have been efficiency claims
4 in these other markets, and I'm -- so let me comment on
5 them.

6 So one of the efficiency claims is that this
7 merger will lead to innovation in healthcare delivery, which
8 is CVS stores are going to be transformed into these
9 healthcare hubs.

10 THE COURT: You mean those one-minute-limit
11 entities?

12 THE WITNESS: One-MinuteClinics.

13 THE COURT: Clinics.

14 THE WITNESS: Maybe MinuteClinics or maybe beyond
15 that.

16 But the way I look at this is, so if you want to
17 innovate in healthcare delivery, maybe you want to partner
18 with people who are experts in healthcare delivery.

19 Aetna is an insurer. It is not in the business of
20 healthcare delivery. It's in the business of insuring
21 people.

22 So then you might ask, So what you'd want to do is
23 come up with a new model.

24 And then that model has to pass the market test,
25 which means, if you're providing high-quality care at low

1 price, customers would want to come to your MinuteClinic or
2 healthcare club or so on.

3 I think what this transaction is doing is it's
4 buying customers.

5 So when you buy Aetna, the insurer, you can now
6 potentially steal Aetna subscribers to your new healthcare
7 delivery model.

8 THE COURT: That's 21 million subscribers.

9 THE WITNESS: 21 million.

10 But now those 21 million subscribers are lost to
11 other innovators in this market.

12 Maybe there's a better model in the healthcare
13 hub. Maybe there's a new app. And whatever it is, those --
14 so those innovators are going to lose out.

15 So in that sense, I don't think this promotes
16 innovation because it blocks some of these 21 million
17 customers from using other innovative models.

18 I'm all for innovation. But I think that
19 innovation has to pass the market test which has forced you
20 to innovate. And if you're selling a good product at a high
21 quality, people would buy that.

22 The second efficiency claim that has been made in
23 these other markets is that the merger will allow for the
24 integration of medical data, with pharmacy data, and that
25 will make CVS a better PBM for Aetna.

1 So -- but if you look at Aetna's press release
2 when they initially signed an agreement with CVS, it -- and
3 I think I have it as an exhibit.

4 THE COURT: Well, I'll tell you what. We're going
5 to take the luncheon recess, okay?

6 THE WITNESS: Okay.

7 THE COURT: You'll be back after lunch, and you'll
8 still have another half hour or so to testify, all right?

9 THE WITNESS: Okay.

10 THE COURT: And you can go into some of those
11 things at that point.

12 THE WITNESS: Sure. That would be great.

13 THE COURT: All right.

14 So we're going to continue our conversation here;
15 reconvene at 2:00. So be back and ready to go at 2:00.

16 THE WITNESS: Yes, sir.

17 THE COURT: And you can step down.

18 THE WITNESS: Thank you, Your Honor.

19 THE COURT: Thank you.

20 Ladies and gentlemen, we'll be returning at 2:00.

21 And like I said before, we won't be going any
22 later than 5:30. But we're going to get the two other
23 witnesses -- we're going to finish this witness, and we're
24 going to get the two other witnesses in this afternoon.

25 We'll take a break until 2:00 in the afternoon.

1 I've strained my wonderful court reporter's patience here by
2 going an hour and a half, but I think he'll survive.

3 So see you at 2:00.

4 MR. QUILLEN: Thank you, Your Honor.

5 DEPUTY CLERK: All rise.

6 (Proceedings concluded at 12:16 p.m.)

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C E R T I F I C A T E

I, William P. Zaremba, RMR, CRR, certify that the foregoing is a correct transcript from the record of proceedings in the above-titled matter.

Date: June 4, 2019 /S/ William P. Zaremba

William P. Zaremba, RMR, CRR

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